Commonwealth of Massachusetts
Executive Office of Health and Human Services

Request and Justification for Therapy Services

When requesting prior authorization for physical, occupational, or speech/language therapy, complete this form and attach it to the request for authorization, whether the request for prior authorization is submitted on paper or using MassHealth's Automated Prior Authorization System (APAS). If using APAS, providers can either download this form from APAS, or complete it on line and submit it electronically as part of the request.

I. Provider information

Provider name	Group practice provider no. (if provider is a part of group practice)	
Provider address	Provider telephone no. ( )	MassHealth provider no.

II. Member information

Last name	First name	MI	MassHealth member ID no.

III. Other insurance information

MassHealth is the payer of last resort. The provider should use diligent efforts to verify whether other insurance exists and to obtain payment from the other insurance.

Other insurance carrier	Policyholder's name	Policy no.

Has the insurance carrier changed since last prior-authorization request? ☐ yes ☐ no

Why is the requested service not covered by this insurance? _____

_____

IV. Physician referral

Referring physician		Address
Primary medical diagnosis name and ICD-9-CM diagnosis code		Secondary medical diagnosis name and ICD-9-CM diagnosis code
Date of onset	Date of referral	Precautions
Reason for referral		

V. Health-related services currently provided to the member

Check all services currently used by member. Indicate the frequency and payer.

Service	Frequency and payer
☐ Adult day health	
☐ Chapter 766/Municipal Medicaid	
☐ Day habilitation	
☐ Early intervention services	
☐ Home health aide	
☐ Hospice	
☐ Nursing services	
☐ Occupational therapy	
☐ Personal care attendant	
☐ Physical therapy	
☐ Speech/language therapy	
☐ Other : _____ (specify)	

VI. Requested services

Location of service delivery: ☐ home ☐ outpatient hospital department ☐ physician's office ☐ rehabilitation center ☐ therapist's office

☐ other (specify) _____

Date of initial evaluation	Rehabilitation potential

Has (or will) the member use all of the visits allowed without prior authorization as part of the current treatment plan? ☐ yes ☐ no

If yes, estimate the number of additional visits that will be needed to achieve treatment goals. _____

How do your goals differ from the other therapy services currently being provided? _____

What other therapy services has the member received in the past 12 months? _____

Who will be responsible for the carryover of the home exercise program, if applicable?

If other than the member, is this person able to attend therapy sessions on a regular basis to obtain training? ☐ yes ☐ no

If yes, has the member been compliant with the home exercise program to date? ☐ yes ☐ no

Please indicate the type, frequency, duration, and length of visit per day that you are requesting.

Type	Frequency per week (i.e., number of visits)	Estimated duration (i.e., weeks, months)	Length of visit per day
Physical therapy			
Occupational therapy			
Speech/language therapy			

VII. Medical necessity

Although most therapy can be viewed as beneficial, MassHealth does not pay for therapy services unless they:

- provide specific, effective, and reasonable treatment of the member's diagnosis and physical condition;
- are directly and specifically related to an active treatment regimen;
- are of a level of complexity and sophistication that the judgment, knowledge, and skills of a licensed therapist are required;
- can achieve a specific diagnosis-related goal; and
- are reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate a handicap, or result in illness or infirmity.

Provide a brief summary below of the medical necessity for the treatment you are proposing, including individual therapies and therapeutic activities. **This field must be completed.**

What are the objective measures you have used to chart progress toward the stated goals? **This field must be completed.**

Important: You must attach a copy of the current physician's referral for all requests in addition to completing this section. For first requests, you must also attach a copy of your initial evaluation. For subsequent requests, you must also attach a copy of the last two evaluations.

Signature

Therapist's name and title

Therapist's signature Date